



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 248526 §
issued to PENNY SUE BRADFORD § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of PENNY SUE BRADFORD, Registered Nurse License Number 248526, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on February 5, 2011, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received an Associate Degree in Nursing from Paris Junior College, Paris, Texas, on May 1, 1979. Respondent was licensed to practice professional nursing in the State of Texas on September 4, 1979.
5. Respondent's nursing employment history includes:

05/1979 - 01/1980	Charge Nurse	Titus Regional Medical Center Mt. Pleasant, Texas
02/1980 - 03/1980	Unknown	

Respondent's nursing employment history continued:

04/1980 - 12/1980	Staff Nurse	Jordan's Home Health Mt. Vernon, Texas
01/1981 - 05/1983	Surgical Nurse	Titus Regional Medical Center Mt. Pleasant, Texas
06/1983 - 07/1983	Unknown	
09/1983 - 10/1985	Surgical Nurse	Charter Suburban Hospital Mesquite, Texas
11/1985 - 12/1988	Surgical Nurse	Titus Regional Medical Center Mt. Pleasant, Texas
01/1989 - 12/1992	Supervisor	ETMC Mt. Vernon Mt. Vernon, Texas
01/1993 - 11/1993	Unknown	
12/1993 - 12/2003	Surgical Nurse	Titus Regional Medical Center Mt. Pleasant, Texas
01/2001 - 01/2007	Supervisor	ETMC Mt. Vernon Mt. Vernon, Texas
01/2007 - 03/2007	Travel Nurse	Liquid Agents Traveling Nurse Springdale, Arkansas
04/2007 - 07/2008	Staff Nurse	Hopkins County Memorial Hospital Sulphur Springs, Texas
08/2008 - Unknown	Charge Nurse	ETMC Mt. Vernon Mt. Vernon, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Hopkins County Memorial Hospital, Sulphur Springs Texas, and had been in this position for one (1) month.
7. On or about May 9, 2007 and May 10, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent withdrew two (2) doses of Tylenol suppository from the dispensary system for Patient Medical Record Number 2393932, but administered one (1) of the doses to the patient and failed to follow the policy and procedure for wastage of the unused dose of Tylenol. Respondent's conduct was likely to defraud the patient of the cost of the medication.

8. On or about August 13, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent failed to implement new orders for a patient after having documented that she had completed the required "chart check". Respondent's conduct exposed the patient unnecessarily to a risk of harm from a delay in treatment of her disease processes.
9. On or about August 22, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent failed to implement a new physician's order to administer home medications, with the exception of Avalide, to a patient after having documented that she had completed the required "chart check". The patient's listed home medications were not added to the Medication Administration Record or provided to the Pharmacy for dispensing / administration to the patient. Respondent's conduct exposed the patient unnecessarily to a risk of harm from medical complications and a delay in treatment of her disease processes.
10. On or about September 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent was noted to be asleep (i.e. "napping") while on duty. Respondent's conduct could have affected her ability to recognize subtle signs, symptoms or changes in the patient's condition, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.
11. On or about September 14, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent failed to complete the admission or shift assessment of Patient Medical Record Number 07831837, as required. Respondent's conduct was likely to injure the patient in that the patient could have undetected disease processes that were not identified and treated in a timely manner and resulted in an incomplete medical record upon which subsequent care givers would use to base their care decisions.
12. On or about October 30, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent failed to note and implement physician's orders to administer medications to Patient Medical Record Number 7156482. Consequently, the patient did not receive multiple doses of medications including Capoten, Celebrex, Effexor, Isosorbide, Elavil, Lasix, Isosorbide, K-Dur, Magnesium Chloride, Synthroid, Vytorin and eye drops. Respondent's conduct exposed the patient unnecessarily to a risk of harm from acute adverse reactions, including hypertension, hypothyroidism, depression and eye disease due to subtherapeutic levels of medications to manage the patient's medical conditions.
13. On or about November 8, 2007, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent failed to appropriately implement a "now" physician's order to obtain a Troponin level for Patient Medical Record Number 9021628, to determine if cardiac injury or myocardial infarction had occurred. Respondent entered the request for a Troponin level as "Routine", resulting in it being done on November 9, 2007. Normal Troponin I level is less than 0.08. The patient's level was 2.03. Respondent's conduct exposed the patient unnecessarily to a risk of harm from medical complications as a result of a delay in treatment for cardiac injury.

14. On or about July 2, 2008, while employed with Hopkins County Memorial Hospital, Sulphur Springs, Texas, Respondent withdrew Demerol for the PCA for Patient Medical Record Number 07505696 but failed to document administration or wastage, as required. At shift change, Respondent passed the Demerol, with tampered packaging, to the oncoming nurse. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers would not have accurate information upon which to base their care decisions. In addition, Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).
15. On or about November 16, 2009, while employed with ETMC Mt. Vernon, Texas, Respondent failed to assess and evaluate the status of Patient Medical Record Number 044114 who was admitted to the Emergency Department for alcohol intoxication and possible tricyclic overdose. In addition, Respondent failed to completely document the status of the patient and the nursing care she provided. Respondent failed to notify the physician of the status of the patient for her entire shift. The next shift nurse found the patient unresponsive, pupils three (3) millimeters, with a Glasgow Coma Score of three (3). The patient required intubation and transfer, via helicopter, to ETMC Tyler for treatment. Respondent's conduct exposed the patient unnecessarily to a risk of harm from undetected progression of clinical complications, including those associated with coma and possible death.
16. In response to Findings of Fact Numbers Seven (7) through Fifteen (15) Respondent states that regarding:
- Finding of Fact Number Seven (7):
- She did not know that this occurred .
 - She did not have experience with the Pyxis dispensing system and that she probably "punched in Patient twice because I didn't know how to exit out or delete so two showed up this way."
- Finding of Fact Number Eight (8):
- She does not remember this incident.
 - She was still in orientation.
 - When she was the Charge Nurse she had to take patients, do all admissions, and check charts.
 - It was overwhelming but she tried to do the best she could under the circumstances.
- Finding of Fact Number Nine (9):
- " I do not remember this."
 - "Patient load had a lot to do with incidents."
- Finding of Fact Number Ten (10):
- She was exhausted from traveling to assist a family member and could not take off any more time from work so she went in to work the night shift.
 - She laid her head down on the desk, with two other nurses present, during her 30minute lunch break.

- "It was not like I was in a room down the hall in the bed asleep."

Finding of Fact Number Eleven (11)

- "You have to take into consideration how many patients I had and the circumstances on the floor at the time. It is easy to sit in an office and look back over the previous day and night shift work and pick it apart if you are not having to take care of patients, Drs. making rounds and dealing with ever demanding family members."

Finding of Fact Number Twelve (12)

- "Once again I don't know about this incident. You have to be in my shoes when you come on to the shift what is thrown at you that days has forgot and then it snowballs onto the night shift and it seemed at this hospital they were continually trying to blame someone for something but were not in any way wanting to help orient you or help with what you were having troubles with."

Finding of Fact Number Thirteen (13)

- "Once again I do not know about this incident."
- "All of these incidents all hinge on a lot of circumstances, you cannot be every where at once."

Finding of Fact Number Fourteen (14)

- The Charge Nurse informed her that the Patient's pain pump was empty.
- She obtained another Demerol Patient Controlled Analgesia, went to the pt's. room and found that there was still 50cc left in the pump. She had already opened the new Demerol PCA but didn't want to waste it so she gave it to the oncoming nurse to replace when the 50cc from the pump had been used.
- "In hindsight I should have wasted it and left it at that."
- "I have been nursing for 29 years and I have never been written up for anything regarding care of a patient. This hospital spends all of its time trying to find fault with nursing and the care but very little on resolving any of the problems with the EMar, E-Charting or the remote pharmacy problems. I had no formal training for the E-Mar or E-Charting."

Finding of Fact Number Fifteen (15)

- "I do feel my documentation was not as complete as it should have been, but in no way did I neglect the patient."
- The Emergency Room Dr. was called several times to come and check the patient. He came down, assessed the patient and stated he thought the patient was intoxicated and did not meet criteria to transfer to Tyler.
- The Dr. was told what Poison Control recommended and to call Poison Control to discuss with the Dr. of Toxicology. He was also told that the patient needed to be monitored in an Intensive Care Unit, which was not available at ETMC Mt. Vernon.
- "It is the Dr's final say in what happens to a patient."
- "I have nursed for 30 years and not once have I been accused of being neglectful of a patient."

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B),(1)(C),(1)(D), (1)(M),(1)(P)&(3)(A) and 217.12(1)(A),(1)(B),(1)(C),(4)&(5).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 248526, heretofore issued to PENNY SUE BRADFORD, including revocation of Respondent's license to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:* <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic

portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*
<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL

NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://learningext.com/hives/a0f6f3e8a0/summary>.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on

RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(7) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(8) For the first year of employment as a Nurse under this Order RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-

employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) years of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S licenses to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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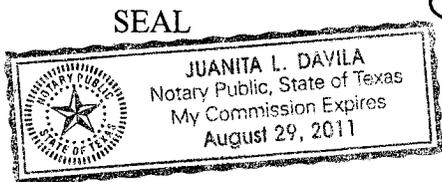
RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 8th day of March, 2011.

Penny Sue Bradford
PENNY SUE BRADFORD, Respondent

Sworn to and subscribed before me this 8th day of March, 2011.



Juanita L. Davila
Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 8th day of March, 2011, by PENNY SUE BRADFORD, Registered Nurse License Number 248526, and said Order is final.

Effective this 28th day of April, 2011.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas", written over a horizontal line.

Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board